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No. 91-1534

Supreme Court, U.S.
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In The Supreme Court of the United States October Term, 1991

TOTAL CARE, INC.,

Petitioner,

v.

LOUIS SULLIVAN, Secretary of the United States Department of Health and Human Services; GAIL WILENSKY, Administrator of the Health Care Financing Administration; GEORGE R. HOLLAND, Regional Administrator of Region IV of the Health Care Financing Administration; JAMES C. HOLLOWAY, Executive Director, Department of Operations for Federal Programs of BLUE CROSS AND BLUE SHIELD ASSOCIATION; and BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA,

Respondents.

PETITIONER'S RESPONSE TO FEDERAL RESPONDENTS' BRIEF IN OPPOSITION

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PETITIONER'S RESPONSE TO FEDERAL RESPONDENTS' BRIEF IN OPPOSITION

I. Introduction

At issue is whether Congress can prevent the courts from exercising Mandamus and/or Federal Question jurisdiction over a Medicare provider's complaint without current exhaustion of administrative remedies where no other forum for relief is provided through the administrative system. This Petitioner has previously exhausted its administrative remedies for the same issue three times.

II. The Medicare Act Restricts The Scope Of Judicial Review On Appeal From The PRRB So As To Preclude Total Care From Presenting Its Present Claims Through The Administrative Forum

Usually, in cases involving Medicare cost report disputes, a provider is required by 42 U.S.C. §1395oo to present its claims to the Provider Reimbursement Review Board ("PRRB" or "Board"), located in Baltimore, Maryland, (provided the jurisdictional amount in controversy is met) before appealing to the court system. The PRRB is only empowered, however, to affirm, reverse, or modify a determination of reimbursement made by the Intermediary and to make other modifications to "matters covered by" the particular fiscal year cost report. 42 C.F.R. §405.1869. The Administrator of the Health Care Financing Administration ("HCFA") then has authority to review the Board's decision. 42 C.F.R. §405.1875. A provider dissatisfied with the Board's or Administrator's decision is entitled to seek judicial review. 42 U.S.C. §1395oo.

The Medicare Act expressly states, however, that the provider's action in court on review from the Administrator's or Board's decision shall be governed by the applicable provisions of chapter 7 of title 5 of the United States Code - the Administrative Procedures Act ("APA"). 42 U.S.C. §1395oo(f). The APA, in turn, limits the court to a consideration of whether the PRRB or Administrator acted arbitrarily or capriciously, with abuse of discretion, not in accordance with the law, or unsupported by substantial evidence. 5 U.S.C. §706.

Respondents' assertion that "the Medicare Act expressly provides that courts may consider legal issues not within the purview of the Board" under §1395oo(f) is simply wrong and contradicts the express language of the Medicare statute.

III. The Present Ad Hoc System For Reimbursing Owner's Compensation Completely Ignores Applicable Medicare Regulations And General Instructions

Medicare regulations issued in 1966 require the Secretary of the U.S. Department of Health and Human Services ("Secretary") to pay "a reasonable allowance" for compensation of owners/executives of Medicare providers:

determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions, . . .[or by] other appropriate means.
42 C.F.R. §413.102.

To effectuate this provision, the Secretary published general instructions to the Intermediary and its subcontractors in 1969 which required them to conduct surveys of compensation paid in comparable institutions and consolidate the survey results into ranges for determining reasonable compensation. The Secretary has never issued any instructions as to what constitutes "other appropriate means" under the regulation. Despite these general instructions, no surveys have been conducted since 1974, and no valid ranges for determining reasonable compensation currently exist. Medicare HIM-15 Chapter 9.

As a result, there is presently a patchwork, ad hoc system for determining reasonable Home Health Agency ("HHA") owners'/executives' compensation which is unfair to providers. This system (which is really not a system at all) offers no advance warning to providers as to what the rules will be to make compensation adjustments; moreover, the system often yields adjustments which the Intermediary cannot subsequently support in the face of a provider's challenge.

Some of the various methodologies used by local intermediaries to adjust home health executives' compensation include:

- The so-called "Michigan survey"
- Ranges of compensation derived from 1964 skilled nursing facility data
- The Independence Blue Cross regression analysis
- The Region V survey of rehabilitation agencies
- The Tennessee Point System
- The Alabama Visit Method
- The Consumer Price Index Method
- The Dunham Study
- The Hay & Associates methodology

Although each of these methodologies is derived from some limited sort of regional compensation data, local intermediaries in other regions of the country often utilize them without modification. For example, Blue Cross and Blue Shield of North Carolina recently utilized the Independence Blue Cross regression analysis, developed in Philadelphia, Pennsylvania from rural Pennsylvania and Maryland HHAs, to adjust owners' compensation for an HHA located in Wilmington, North Carolina. See Comprehensive Home Health Care I, Inc. v. Sullivan et. al., No. 99-9-CIV-7 (E.D.N.C. 1990). Similarly, Blue Cross and Blue Shield of Mississippi utilized the Tennessee Point System based on a computer listing of unidentified HHAs in rural Tennessee to adjust the salary of an HHA administrator working in Mississippi. Alexander's Home Health Agency, PRRB Hearing Dec. No. 88-D30 (September 2, 1988). There is no evidence, however, that what constitutes reasonable owners'/executives' salary in one region (e.g., in Philadelphia) also constitutes equally reasonable salary in another region (e.g., Wilmington, North Carolina). In addition, problems arise out of the methodologies listed above which use some system for awarding "points" (typically on a scale of 1 to 10) to an administrator based on a variety of factors allegedly relevant to determining an appropriate salary (e.g., years of experience, education, size of agency). Under these point system methodologies, "reasonable" salary is based solely on the total number of points awarded to the particular HHA owner/administrator. These systems are faulty, however, for a number of reasons.

First, there is no statistical support for the link between certain factors measured by the point systems and appropriate salary. Second, there is no evidence that the total number of points awarded under such systems fairly reflects the level of responsibility of an HHA owner/administrator (which should form the basis for determining appropriate salary). Third, different point systems use different factors for determining allowable salaries without evidencing the appropriateness of applying different factors to HHAs located in different regions or even within the same region. Finally, the point systems typically derive one fixed salary for all HHA owner/administrators who receive the same number of points, rather than indicating an appropriate salary range for the position. A range is clearly more appropriate because it allows more effective administrators to receive a reasonably higher salary than ineffective administrators with the same number of objectively-measured points.

Respondents argued below that the Secretary has acted pursuant to the owners' compensation regulation by allowing the Intermediary to develop "other appropriate means" for determining reasonable executive salaries All such "means," however, have consisted of post-hoc rationalizations. While the Secretary's interpretation of federal regulations is to be given great weight, the interpretation must be reasonable in light of the language of the regulation and the policy meant to be implemented. McCuin v. Secretary, 817 F.2d 161, 168 (1st Cir. 1987). If the Secretary's procedures under a regulation are not reasonable, the courts may invoke mandamus or federal question jurisdiction to hear a complainant's challenges - even though the court could not accept jurisdiction over a challenge to an amount determination brought by the same provider. McCuin, 817 F.2d at 166.

IV. By Prohibiting Jurisdiction In This Case, The Court Will Create Far-Reaching Implications For All Regulated Parties And Administrative Agencies In The United States

If the Respondents are protected from scrutiny in this case for failing to follow Medicare regulations and general instructions

pertaining to owners' compensation, a dangerous precedent will be set for Medicare and all other administrative agencies.

First, there will be nothing to stop the Respondents in this case from refusing to follow other regulations and general instructions relating to other Medicare matters. A decision to deny the courts' jurisdiction over issues outside the purview of the Medicare administrative system clearly allows the Secretary and Intermediary to operate without check on all Medicare matters which do not involve claims for reimbursement subject to PRRB review.

Second, because they will have no opportunity for redress through either the administrative or judicial system, providers (including hospitals and nursing homes, etc.) will face no choice but either to accept arbitrary actions by the government or stop participating in the Medicare Program altogether. Thousands of PRRB appeals on cost report disputes are already filed each year through the Medicare Program which challenge the amount of reimbursement paid in particular cases, and a backlog is resulting. In fact, the PRRB is currently scheduling hearings for 1995 on reimbursement claims arising from cost reporting years ending prior to 1992. It is unlikely that many providers will continue to participate in the Medicare Program if both the rules and amounts are always at issue.

Finally, a decision by this Court to refuse jurisdiction in the present case would substantially reduce the accountability of all regulatory agencies. The jurisdictional issues raised in this case affects all regulated parties - not just Medicare providers - and involves fundamental questions of constitutional and administrative law and the right of all regulated parties in this country to enforce the law against the government.

V. Respondents' Arguments That §405(h) Precludes Jurisdiction In This Case Are In Error

As stated above, The Fourth Circuit held that §405(h) precludes jurisdiction in this case. Total Care, Inc. v. Sullivan, No. 91-1514 (4th Cir. 1991). Other circuits, however, would clearly have accepted jurisdiction in this case because Total Care's complaint does not

involve a "claim" for reimbursement under the Medicare Act, and its complaint is not subject to review by the PRRB. There is therefore a split in the circuits on the issues raised herein, and this case is suitable for review by this Court. In addition, nothing can be gained by postponing judicial review any further as the Secretary has already failed to act in over twenty years.

A. The Circuit Courts Of Appeals Are Divided On The Issue Of Jurisdiction In Light Of §405(h) Because Of The Important Constitutional Questions Raised

Recent cases in circuits other than the Fourth Circuit hold that §405(h) does not preclude judicial review in Medicare cases that raise issues outside the scope of administrative review. These cases state that federal question and/or mandamus jurisdiction are available for causes of action which are otherwise unreviewable despite §405(h).

In their reply brief filed with this Court, Respondents rely primarily on this Court's decision in Heckler v. Ringer, 466 U.S. 602 (1984), for their argument that §405(h) precludes the courts from exercising federal question jurisdiction in this case (Brief for Federal Respondents in Opposition ("Resp.") at pp. 9-11). During the years since Ringer was decided in 1984, however, various courts have also addressed the jurisdictional issue. While the Fourth Circuit concluded that §405(h) bars jurisdiction even where no other avenue for relief is available, other courts have decided that jurisdiction in such cases is not precluded.

For example, in Beverly Hospital v. Bowen, No. 88-5011 (D.C. Cir. 1988), several hospitals successfully challenged a Medicare regulation which required them to provide photocopies of medical records to peer review organizations at their own expense. The Secretary tried to argue that 42 U.S.C. §1395oo, which requires presentation of claims to the PRRB, was the exclusive avenue for relief for the providers. The United States Court of Appeals for the District of Columbia Circuit, however, held that:

The 42 U.S.C. §1395oo route is indeed exclusive when it is genuinely

available to provide redress; when that is not the case, however, parties may invoke general federal question jurisdiction, 28 U.S.C. §1331 (1982), as was done in this case and in Burlington Memorial Hospital [644 F.Supp. 1020 (W.D. Wis. 1986)]. See National Ass'n of Home Health Agencies v. Schweiker, 690 F.2d 932, 936-41 (D.C. Cir. 1982), cert. denied, 459 U.S. 1205 (1983); College of Am. Pathologists v. Heckler, 734 F.2d 859, 862-63 (D.C. Cir. 1984). Beverly Hospital, as reprinted in Medicare and Medicaid Guide (CCH) ¶37,814 at p. 19789; see also American Hospital Association v. Sullivan et. al., No. 88-2027 (D.D.C. 1990). The court went on to criticize the Secretary for wanting to send the providers back to the Intermediary and PRRB with no valid regulations to apply. The court stated that "[b]ureaucratic ordering of this sort should not go unchecked by a reviewing court." Id. at pp. 19789-19790.

Similarly, the Secretary in the present case would send Total Care back to continually re-present its claims against the lack of salary guidelines to the Intermediary and PRRB without developing any valid methodology for them to apply. For over twenty years the government has failed to enforce the applicable Medicare regulations and general instructions which require the development of a rational system for making salary adjustments. As the PRRB lacks any power to order the Secretary to enforce his own rules on this matter, Total Care's present claims could not be addressed by another attempt at such a futile process.

As one circuit court recently stated:

[T]he Secretary cannot relegate providers to a dead-end procedure under the Medicare statute, and then argue that the provider loses because the Medicare statute is the exclusive means of redress. When such bureaucratic red tape strangles a provider's right to judicial review, the court may invoke its federal question jurisdiction. Memorial Hospital v. Sullivan, No. 91-727 (D.C.Cir. 1991) as reprinted in CCH ¶39,723 at pp. 28,718-28,719.

In American Hospital Association v. Sullivan, several hospital associations challenged a Medicare regulation, which prohibited providers from billing liability insurers, as being in violation of the "secondary payor" provisions of the Medicare Act. The Secretary

sought to dismiss the case for lack of jurisdiction under 42 U.S.C. §1395oo. The district court stated that:

Courts have recognized that when a particular case is not cognizable under any of the administrative schemes set up in the Medicare statute, then a District Court does have jurisdiction to hear the matter. American Hospital Association, as reported in CCH ¶38,537 at p. 23,017-6.

For cases where courts have accepted mandamus jurisdiction despite §405(h) on similar grounds, see Samaritan Health Center v. Heckler, 636 F.Supp. 503 (D.D.C. 1985); Hennings v. Heckler, 601 F. Supp. 919 (N.D. Ill. 1985), citing City of New York v. Heckler, 742 F.2d 729 (2d Cir. 1984), aff'd, Bowen v. New York, 476 U.S. 467 (1986), Dietsch v. Schweiker, 700 F.2d 865 (2d Cir. 1983), Lopez v. Heckler, 725 F.2d 1489 (9th Cir. 1984) vacated and remanded on other grounds, 469 U.S. 1082 (1984), Mental Health Association of Minnesota v. Heckler, 720 F.2d 965 (8th Cir. 1983), Belles v. Schweiker, 720 F.2d 509 (8th Cir. 1983), Ellis v. Blum, 643 F.2d 68 (2d Cir. 1981), Bellantoni v. Schweiker, 566 F.Supp. 313 (E.D.N.Y. 1983), Dixon v. Quern, 537 F.Supp. 990 (N.D.Ill. 1982), Silvis v. Heckler, 578 F.Supp. 1401 (W.D.Pa. 1984), Sinatra v. Heckler, 566 F.Supp. 1354 (E.D.N.Y. 1983).

B. Nothing Can Be Gained By Dismissing This Case Back To The Administrative System

Contrary to Respondents' assertions, judicial review over this case would not "prematurely interfere" with the administrative agency process or prevent the agency from "applying its expertise" (see Resp. at p. 11). The agency is currently taking no action on the issue of owners' compensation and has not taken any such action since 1974.

In addition, dismissing this case in favor of administrative remedies would clearly not "obviate the need for judicial review," as Respondents argue (see Resp. at p. 11). The reason is simply that the administrative process lacks authority to address the provider's claims.

Moreover, federal regulations require the Intermediary to determine reasonable executive compensation based on "comparable" salaries

paid in comparable facilities or "other appropriate means." As the Secretary has not enforced his instructions under this regulation in over twenty years, it is unlikely that, absent judicial intervention, we can expect him voluntarily to do so in the near future.

C. Total Care's Complaint Does Not Involve A "Claim" Under The Medicare Act Subject To Redress Through The Administrative Procedure

Section 405(h), by its terms, involves only a "claim" arising under the Medicare Act. Several courts have held that challenges to methodology - rather than amount - are not "claims" subject to the restrictions of this section.

Recently, in Americare Home Health Agency v. Sullivan, et. al., No. 90-2950-HB (D.Tenn. 1992), Blue Cross and Blue Shield of South Carolina (one of the same Respondents in the present case before this Court) attempted to recoup certain overpayments made to an HHA by means of offset without complying with applicable Medicare regulations. In response to a suit filed by the HHA, the defendants argued that the claim was barred by §405(h). The court held, however, that the HHA's complaint was not a "claim" arising under the Medicare Act, but dealt with the defendants' method of recouping alleged overpayments in violation of federal regulations.

The court quoted extensively from an earlier decision in Elk Valley Professional Affiliates, Inc. v. Sullivan, No. 4-90-198 (E.D. Tenn. 1991), where the magistrate stated:

This is not a case where the claims are, "at bottom," claims about how much the Medicare program should pay plaintiff for services performed. [] Plaintiff concedes that "how much" claims are subject to the administrative process. The plaintiff does not seek increased Medicare reimbursement; rather, the plaintiff seeks to compel the defendant [Secretary] to follow the federal regulations regarding the appropriate method of recouping an alleged overpayment. If the defendant is right that there is an . . . overpayment, the defendant will recover all of that money, with interest, regardless of what takes place

in this lawsuit. This case will in no way affect the administrative appeals process.

Where, as here, a plaintiff's claims are not within the statutory jurisdiction of the administrative review entity, jurisdiction can be based upon 28 U.S.C. §1331[]. I find that the court has subject matter jurisdiction... Id. at pp. 29,607-29,608 (emphasis in original).

Similarly, as Total Care has repeatedly stated, this lawsuit is not a "how much" claim for increased reimbursement for executive compensation. Contrary to Respondents' arguments, that Total Care prevailed at the PRRB is not determinative because this lawsuit seeks to enforce the stated methods for making executive compensation adjustments under federal regulations. Moreover, there is no guarantee that Total Care would receive increased reimbursement under the system it seeks to enforce. As no valid surveys of "comparable" providers have ever been performed and as no rules explain "other appropriate means," there is no way of telling how Total Care's owners' salary compares to other providers.

Finally, this case does not hamper the administrative appeals process which has proceeded on its own course while this case has progressed through the courts. This case simply seeks to enforce the federal regulatory system for determining reasonable owners' compensation so that providers, the Intermediary, and the PRRB have valid rules to apply.

VI. Conclusion

For all of the foregoing reasons, the Petitioner respectfully requests that this Court issue a writ of certiorari in this case.

Respectfully submitted,

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